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Supreme Court, U.S.
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No. 96-1742

In The

Supreme Court of the United States

October Term, 1996

KIMBERLY BELSHÉ, Director of the State Department of Health Services, State of California,

Petitioner,

vs.

ORTHOPAEDIC HOSPITAL and the CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

Respondents Orthopaedic Hospital and the California Association of Hospitals and Health Systems ("Respondents" or "Hospitals") disagree with the questions presented in the Petition for Writ of Certiorari with respect to the first question presented. Properly phrased, the questions presented are:

1. Does 42 U.S.C. § 1396a(a)(30)(A) require state Medicaid agencies to consider the costs that hospitals incur in delivering services when setting payment rates for hospital outpatient services; require that hospital outpatient reimbursement rates bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services; and require that states rely on hospital costs as a basis for setting Medicaid rates for hospital outpatient services?

2. Does 42 U.S.C. § 1396a(a)(30)(A) create a private right of action for health care providers under 42 U.S.C. § 1983?

STATEMENT PURSUANT TO RULE 29.6

Pursuant to Supreme Court Rule 29.6, Respondents hereby inform the Court that Orthopaedic Hospital is a nonprofit corporation which has no parents or nonwholly subsidiaries. The California Association of Hospitals and Health Systems, the other Respondent herein, is a corporation which has no parents and one nonwholly owned subsidiary as follows: California Hospitals Affiliated Insurance Services, Inc.

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APPENDIX

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OPINION BELOW

Respondents request that the Court deny the Petition for Writ of Certiorari for review of an opinion of the Court of Appeals for the Ninth Circuit. The Court of Appeal's opinion is reported at 103 F.3d 1491 (9th Cir. 1997), *reh'g denied and suggestion for reh'g en banc denied*, (9th Cir. Mar. 27, 1997), *petition for cert. filed*, 65 U.S.L.W. 3755, 3755 (U.S. May 13, 1997). A copy of the Ninth Circuit Opinion is reproduced in Appendix A to the Petition, and a copy of the Order of the Ninth Circuit denying rehearing and rehearing en banc is reproduced in Appendix C to the Petition. For the convenience of the Court, Respondents will cite to both the Opinion attached as Appendix A to the Petition and to the official reporter when referencing the Ninth Circuit Opinion in this case.

STATEMENT OF JURISDICTION

The Petition's statement of jurisdiction is accurate as it applies to the first question presented, *i.e.*, the proper interpretation of 42 U.S.C. § 1396a(a)(30)(A). However, it would be inappropriate for the Court to exercise jurisdiction over the second question presented, whether Section 1396a(a)(30)(A) creates a private right of action for health care providers under 42 U.S.C. § 1983, because this issue was never presented to the Ninth Circuit. *See infra* part II.A.

STATEMENT OF THE CASE

A. Course Of Proceedings And Disposition Of The Case Below

Under California's Medicaid program, known as Medi-Cal, hospitals are reimbursed for outpatient services the lower of the hospital's actual charges or fixed rates adopted by the California

Department of Health Services ("Department" or "Petitioner"), the California agency responsible for administering Medi-Cal. With a few exceptions, the Medi-Cal payment rates for hospital outpatient services have remained frozen for more than eleven years, since August 1985. 3 A.R. at 240-41.[1] During California's fiscal year ending June 30, 1992, the Medi-Cal outpatient hospital rates reimbursed only about 41 percent of hospitals' costs. 3 A.R. at 72-76, 378-449.

In August 1990, Orthopaedic Hospital and the California Association of Hospitals and Health Systems, the Respondents herein, brought suit in the United States District Court for the Central District of California, challenging the validity of the Medi-Cal hospital outpatient rates. *Orthopaedic Hosp., et al. v. Kizer*, No. 90-4209 SVW (JRx) (C.D. Cal.) ("*Orthopaedic I*"). The Hospitals contended that the rates violated two provisions of the federal Medicaid Act, 42 U.S.C. § 1396a(a)(13)(A) (the "Boren Amendment"), and 42 U.S.C. § 1396a(a)(30)(A), the statute at issue herein.

The district court in *Orthopaedic I* ruled that the Boren Amendment does not apply to hospital outpatient services, but that Section 1396a(a)(30)(A) does apply to such services. Further, the court held that health care providers have a private right of action under 42 U.S.C. § 1983 to challenge Medicaid payment rates on the ground that they violate Section 1396a(a)(30)(A). *See Orthopaedic Hosp. v. Kizer*, No. 90-4209 SVW (C.D. Cal. June 28, 1991) at 7, 11 (Order Denying Summary Judgment and Requesting Further Briefing).

The district court in *Orthopaedic I* reviewed seven rate settings that occurred in and after August 1985. The court held that the Department had acted arbitrarily and capriciously in

1. References to "3 A.R." are to volume 3 of the administrative record on file in this case.

six of the seven rate settings because it had failed to consider the relevant factors of efficiency, economy and quality of care set forth in Section 1396a(a)(30)(A) when adopting the rates. *Orthopaedic Hosp. v. Kizer*, No. 90-4209 SVW (JRx) (C.D. Cal. Oct. 8, 1992) at 8-9, 35 (Order Granting Plaintiffs' Motion for Summary Judgment). The district court remanded the matter to the Department for further proceedings consistent with the court's opinion. *Id.* at 36.

The district court revised its judgment twice. First, the court stated that it had not invalidated the rates and that the Department could apply them during the remand proceedings. *Orthopaedic Hosp. v. Kizer*, No. 90-4209 SVW (JRx) (C.D. Cal. Nov. 20, 1992) at 2 (Order Correcting Judgment). Second, to discourage delay, the court ordered that any new rates were to be applied retrospectively from the date of the court's original decision, October 8, 1992. *Orthopaedic Hosp. v. Kizer*, No. 90-4209 SVW (JRx) (C.D. Cal. Feb. 16, 1993) at 4 (Order Amending the Revised Judgment).

In a final administrative decision issued on April 15, 1994, more than one and one-half years after the court's October 8, 1992 judgment and remand, the Department announced that it "determined that there is no basis for changing existing Medi-Cal reimbursement for outpatient services. . . ." The Department therefore readopted the existing rates without change. 3 A.R. at 1.

The Hospitals returned to the district court to challenge the readoption of the rates in Case Nos. 94-4825 ("*Orthopaedic II*") and 94-4764 ("*Orthopaedic III*"). Once again, the district court held that the Hospitals have a private right of action under 42 U.S.C. § 1983 to enforce Section 1396a(a)(30)(A). *Orthopaedic Hosp. v. Belshe*, Nos. 94-4764, 94-4825 (C.D. Cal. Mar. 24, 1995) at 9 (Order Denying Plaintiffs' Motion for Summary

Judgment and Granting Summary Judgment for Defendant) (Appendix B at 9).[2] However, the district court concluded that the Department on remand had adequately considered efficiency, economy and quality of care and entered judgment for the Department. *Id.* at 24-25 (Appendix B at 25-26).

The Hospitals appealed to the Ninth Circuit, which reversed the district court's judgment. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1500 (9th Cir. 1997) (Appendix A at 22). The Ninth Circuit held that Section 1396a(a)(30)(A) requires the Department to set hospital outpatient rates that bear a reasonable relationship to an efficient and economical hospital's costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. *Id.* To comply with this requirement, the court ruled that the Department "must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting." *Id.* at 1496 (Appendix A at 13).

The Ninth Circuit reasoned that because Section 1396a(a)(30)(A) requires Medi-Cal payments themselves to be consistent with quality care, the Department must consider the costs of providing quality care in adopting the rates. *Id.* (Appendix A at 13). The Court rejected the Department's argument that "it doesn't have to pay the cost of quality care because hospitals are contractually obligated to provide quality care once they agree to take Medicaid patients, and because hospitals' licensing requirements require them to provide quality care." *Id.* at 1497 (Appendix A at 14-15).

The Ninth Circuit noted that because the Department maintained that the Medi-Cal payments did not have to bear

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2. All references to appendices are to the appendices attached behind the Petition, unless otherwise noted.

any relationship to hospital costs, the Department did not even argue that it had considered them. *Id.* at 1499 (Appendix A at 20). Thus, the court held that "the Department's actions were arbitrary and capricious and contrary to law." *Id.* at 1500 (Appendix A at 22). The court remanded the matter to the Department to determine the costs incurred by efficient hospitals economically providing quality outpatient services, and to set rates that bear a reasonable relationship to such costs, with the state bearing the burden of justifying any rate that substantially deviates from such costs. *Id.*

The Ninth Circuit denied the Petitioner's petition for rehearing and rejected the suggestion for rehearing en banc. No judge of the Ninth Circuit requested a vote on the suggestion for rehearing en banc. Appendix C at 2.

B. Correction Of Misstatements In The Petition Affecting The Issues Properly Before The Court

The Petition, at pages 9-10, states:

> In distinguishing the requirements imposed upon states by the Boren Amendment from those imposed by 42 U.S.C. § 1396(a)(30)(A) [sic], the Department queried whether 42 U.S.C. § 1396a(a)(30)(A) creates a private right of action for health care providers under 42 U.S.C. § 1983.

The Petition implies that the Department raised before the Ninth Circuit the question of whether a private right of action is available to health care providers under 42 U.S.C. § 1983 to enforce Section 1396a(a)(30)(A). However, although the Department did raise this issue before the district court in both *Orthopaedic I* and *Orthopaedic II/III*, and the district court ruled

against the Department in each instance, the Department did not raise this issue before the Ninth Circuit. This issue was not raised by the Department in a cross appeal, was not addressed by the Department in its brief or at oral argument, and was not raised in the Department's petition for rehearing. Additionally, this issue was not addressed by the Ninth Circuit in its published opinion.

REASONS FOR DENYING THE PETITION

I.

THE FIRST QUESTION PRESENTED — THE NINTH CIRCUIT'S INTERPRETATION OF SECTION 1396a(a)(30)(A)

A. The First Question Presented Does Not Involve A Question Of Exceptional National Importance As Asserted By The Petition

While the Ninth Circuit's decision is clearly of importance to California hospitals, it does not involve a question of exceptional national importance warranting Supreme Court review. The issue decided by the Ninth Circuit is a narrow one: the interpretation of a single provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), as it applies to reimbursement rates for hospital outpatient services. *See Orthopaedic Hosp.*, 103 F.3d at 1500 (Appendix A at 22) (section of Opinion entitled "Conclusion" speaks solely of hospital outpatient services). The Ninth Circuit carefully stated its holding solely in the context of hospital outpatient services. The Ninth Circuit did not purport to interpret Section 1396a(a)(30)(A) as it might apply to other services.

Further, the Ninth Circuit decided this case with reference to and in view of the specific circumstances presented to the

court. For example, the court emphasized that hospitals provide most of the outpatient services that are furnished under Medi-Cal and afford access to Medi-Cal beneficiaries due to factors which are unrelated to reimbursement levels. *Id.* at 1496-97, 1498 (Appendix A at 14, 17). Thus, the court concluded that the fact that hospitals are willing to furnish outpatient services to Medi-Cal patients does not indicate that the rates are consistent with efficiency, economy, and quality of care as might be the case with other types of providers. *Id.* at 1498 (Appendix A at 18).

Additionally, the Ninth Circuit was faced with rates that had not been revised for more than eleven years and that reimbursed only a small percentage of hospital costs. 3 A.R. at 72-76, 240-41, 378-449, 1156-57. The court emphasized that the Department did not consider hospital costs in readopting the rates, because the Department did not believe that it was required to do so. *Orthopaedic Hosp.*, 103 F.3d at 1498 (Appendix A at 20).

The Ninth Circuit also emphasized that, although the Department argued it was inappropriate to pay more to hospitals than to other types of providers for outpatient services simply because hospitals' costs were higher, the Department had failed to furnish any incentives for Medi-Cal beneficiaries to use less costly providers. *Id.* at 1496-97, 1498 (Appendix A at 14, 18). The court noted that many hospitals are legally obligated to furnish outpatient services to Medi-Cal patients as a result of operating emergency rooms, and that undercompensating hospitals did nothing to shift Medi-Cal patients to less costly settings. *Id.* at 1496, 1498 (Appendix A at 14, 17-18).

Faced with these particular circumstances, the Ninth Circuit concluded that it was not consistent with efficiency, economy, and quality of care for the Department to establish rates for

hospital outpatient services that were simply the same as rates paid to non-hospital providers and which did not take into account hospitals' costs. Clearly, the Ninth Circuit's construction and application of Section 1396a(a)(30)(A) are intertwined with the specific facts presented to the court. It is highly unlikely, therefore, that the court's decision will have widespread implications.

The fact that this case does not present an issue of widespread importance is reflected by the very few cases that have addressed Section 1396a(a)(30)(A). During the 29 years since the statute's enactment in 1968, there have been only five published United States Court of Appeals decisions addressing Section 1396a(a)(30)(A).[3]

Furthermore, because the Ninth Circuit's decision is based on the specific facts of this case, whether the standard adopted by the Ninth Circuit might apply to other types of providers or other state Medicaid programs involving their own unique circumstances is best left for the orderly development of the law arising from specific cases to be presented to the lower courts.

In an effort to convince this Court of the importance of the Ninth Circuit's interpretation of Section 1396a(a)(30)(A), the Department argues that the implementation of the court's decision will create administrative chaos, have a devastating fiscal impact, and lead to a litigation explosion. Petition at 22-27. The Department's contentions are wholly exaggerated and do not warrant this Court's review of the Ninth Circuit's decision.

Significantly, the Department did not raise the

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3. *Minnesota Homecare Ass'n, Inc. v. Gomez*, 108 F.3d 917 (8th Cir. 1997); *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997); *Visiting Nurse Ass'n of N. Shore, Inc. v. Bullen*, 93 F.3d 997 (1st Cir. 1996), *cert. denied*, 117 S. Ct. 955 (1997); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026 (7th Cir. 1996); *Arkansas Medical Soc'y, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993).

administrative problems it now advances until its petition for rehearing before the Ninth Circuit. Yet, it had always been the Hospitals' position, both before the Ninth Circuit and the district court, that Section 1396a(a)(30)(A) requires hospital outpatient rates to bear a reasonable relationship to hospital costs. The Department's failure to raise these concerns on a timely basis before the Ninth Circuit makes them inappropriate for review by this Court.[4]

Moreover, the Department's apocalyptic description is not accurate. This case concerns payments for hospital outpatient services, not payments for the many non-hospital providers for which the Department asserts the gathering of cost data would be particularly difficult. Hospitals submit annual cost reports to the Medicare and Medi-Cal programs, as well as detailed financial disclosure reports to the California Office of Statewide Health Planning and Development, which set forth the costs incurred by hospitals in furnishing services, including outpatient services. *See* 42 C.F.R. §§ 413.24(f), 447.253(f); Cal. Health & Safety Code §§ 128730 et seq.

The administrative record reflects that these data sources can be used to compute hospital outpatient costs, and that these data were used by the Hospitals' expert, Dr. Henry Zaretsky, in the analyses he performed comparing hospital outpatient costs to the Medi-Cal payment rates. *See Orthopaedic Hosp.*, 103 F.3d at 1495 (Appendix A at 10); 3 A.R. at 449. Dr. Zaretsky's analysis did not take an enormous period of time, involve a "staggering number of personnel," or involve the type of substantial costs suggested by the Department.

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4. The Ninth Circuit routinely refuses "to consider on petitions for rehearing arguments not raised in a brief or at oral argument. . . ." *Northern Mariana Islands v. Lizama*, 27 F.3d 444, 448 (9th Cir. 1994); *Boardman v. Estelle*, 957 F.2d 1523, 1535 (9th Cir.), *cert. denied*, 506 U.S. 904 (1992) (arguments raised for first time in petition for rehearing are deemed waived).

The Department asserts that it would have difficulty determining whether quality care was being furnished because it does not license services furnished outside of an institutional setting. Petition at 23. The Department, however, clearly does have the obligation to license hospitals and to monitor their quality. This case involves only hospital outpatient services. Further, the Department's Rate Study discusses at length steps that the Department and other California state agencies take to ensure that quality services are furnished by all providers. *See* 1 A.R. at 45-51.

Even if implementation of the Ninth Circuit's decision were to present administrative difficulties, however, these difficulties would not justify a different result. *Withrow v. Concannon*, 942 F.2d 1385, 1387-88 (9th Cir. 1991); *Souder v. Brennan*, 367 F. Supp. 808, 814 (D.D.C. 1973) ("administrative burden is no excuse for failure to implement the statutory mandate.").

The Department asserts in the Petition that the implementation of the Ninth Circuit's decision could cost hundreds of millions of dollars annually. Petition at 26. However, the Department has failed to point to any evidence in the record as to the cost of implementation. Rather, the Department refers to the Declaration of James Taylor attached to its Motion for Stay of Mandate filed in the Ninth Circuit in which Mr. Taylor speculates that the cost of implementing the decision "could be hundreds of millions of dollars." The Department has never actually determined what it costs hospitals to provide quality outpatient services efficiently and economically. Thus, the Department is in no position to advise the Court regarding the cost of implementing the Ninth Circuit's decision. Moreover, the fact that it might cost one state substantial sums to comply with the Ninth Circuit's decision, does not indicate that the Ninth Circuit's decision presents the type of case of national importance to warrant Supreme Court review.

The Department asserts that the Ninth Circuit's decision will likely lead to an explosion of complex litigation. Petition at 26-27. As indicated above, however, in the 29 years since the enactment of Section 1396a(a)(30)(A), there have only been 5 court of appeals decisions addressing its application. This hardly foretells a litigation explosion.

Further, the Department's concerns that the Ninth Circuit's decision would open the floodgates to complex litigation are premature. The Ninth Circuit's decision is binding only in the Ninth Circuit, and it is unknown at this point whether other Circuits will follow the Ninth Circuit. The Ninth Circuit's decision addresses only hospital outpatient services, and it is unknown whether the Ninth Circuit would apply a similar rule to other services. California hospitals were faced with particularly egregious circumstances which caused them to file suit (*i.e.*, rates that had been frozen for many years and that paid a small percentage of costs), and it is unknown whether similar facts are present in other states.

Finally, the Department implies that cases challenging Medi-Cal rates under Section 1396a(a)(30)(A) are too complicated to be heard by the federal courts, citing several alleged errors in the decision here. Petition at 28. This is utter nonsense. The federal courts are fully competent to determine whether rates bear a reasonable relationship to costs and are based on responsible cost studies. Indeed, the Ninth Circuit's comprehensive, well reasoned decision in this case evidences the federal courts' competence to adjudicate Medicaid rate cases under Section 1396a(a)(30)(A).

B. There Is No Conflict Among The Circuits

The Department asserts that the Ninth Circuit's interpretation of Section 1396a(a)(30)(A) conflicts with recent decisions of

the Seventh and Eighth Circuits, citing *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026 (7th Cir. 1996) and *Minnesota Homecare Association, Inc. v. Gomez*, 108 F.3d 917 (8th Cir. 1997). Petition at 11-12. The Ninth Circuit's decision, however, is not in conflict with either of these decisions.

Methodist Hospitals does not address the efficiency, economy, and quality of care standard set forth in Section 1396a(a)(30)(A), which is the key language in the statute on which the Ninth Circuit relied. Rather, *Methodist Hospitals* focuses solely on the equal access language. *See Methodist Hosps.*, 91 F.3d at 1029. *Methodist Hospitals*, therefore, is certainly not in conflict with the Ninth Circuit's construction of the efficiency, economy, and quality of care standard.

Methodist Hospitals rejected the plaintiffs' argument that a state must conduct a complete supply and demand analysis for every medical specialty in every part of the state prior to changing reimbursement rates so that the state knows exactly what effect a new rate will have on the demand for and supply of medical care. *Id.* at 1029-20. Here, the Hospitals have not requested, nor has the Ninth Circuit ordered, that any such supply and demand studies be conducted. Rather, the Ninth Circuit has required the Department to study hospitals' costs of providing outpatient services.[5]

Similarly, the holding of the Ninth Circuit is not inconsistent with *Minnesota Homecare Ass'n*. That case involved services

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5. The amici curiae argue that *Methodist Hospitals* indicates that Section 1396a(a)(30)(A) is concerned with the result achieved by the payment rates, while the Ninth Circuit in contrast is concerned with the rate-setting methodology. Brief of Amici Curiae at 6-8. However, the Ninth Circuit is primarily concerned with the result of the Department's rate-setting methodology, *i.e.*, that it produce rates which bear a reasonable relationship to costs. *Orthopaedic Hosp.*, 103 F.3d at 1496, 1500 (Appendix A at 13, 22).

furnished by home health agencies and did not involve payments for hospital outpatient services. *See Minnesota Homecare Ass'n*, 108 F.3d at 918.

Further, the plaintiffs in *Minnesota Homecare Ass'n* challenged generally the methodology used to establish home health reimbursement rates, but did not challenge the rates themselves. *Id.*[6] Here, the Hospitals have challenged the Medi-Cal rates themselves and the Department's decision to readopt the rates, not just the rate-setting methodology.

The *Minnesota Homecare Ass'n* holding is that states need not employ any specific methodology in adopting rates. *Id.* In the instant case, the Ninth Circuit has not ordered the Department to adopt a specific methodology. Rather, the Ninth Circuit has simply ordered the Department to ensure that the rates bear a reasonable relationship to costs, with the Department bearing the burden to show justification for a *substantial* departure from costs. *Orthopaedic Hosp.*, 103 F.3d at 1500 (Appendix A at 22). Within these broad parameters, the Ninth Circuit has not prescribed a specific methodology to be used.

Finally, and perhaps most importantly, neither *Methodist Hospitals* nor *Minnesota Homecare Association* addresses the question of whether reimbursement rates must bear a reasonable relationship to hospital costs. Therefore, neither decision conflicts with the Ninth Circuit's holding in *Orthopaedic II/III*.[7]

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6. That the methodology and not the rates were in dispute is clearly reflected in the district court's memorandum and order. *Minnesota Home HealthCare Ass'n v. Gomez*, No. 3-94-1570 (D. Minn. Feb. 14, 1996) at 4-5. The district court's unpublished memorandum and order are attached hereto as Respondents' Appendix A.

7. The Ninth Circuit's decision in *Orthopaedic II/III* is consistent with the only decision that squarely addresses whether Medicaid rates for hospital

(Cont'd)

C. The Ninth Circuit Correctly Construed Section 1396a(a)(30)(A)

The Ninth Circuit's interpretation of Section 1396a(a)(30)(A) is consistent with, and is compelled by, the plain language of the statute. The Ninth Circuit properly concluded that a statute requiring payments to be consistent with quality of care requires that the payments be adequate to reimburse the costs of furnishing quality care.

For example, if it costs hospitals operating efficiently and economically $100 to provide a particular service of high quality, it would not be consistent with quality of care to reimburse hospitals only $50 for that service. This is the thrust of the Ninth Circuit's decision, and it is entirely consistent with the plain language of the statute.

The Department, apparently in an attempt to demonstrate unreasonableness in the Ninth Circuit's decision, asserts that "[i]t is likely that a payment standard based on provider costs has never been applied by any third-party payor (i.e, Medicaid, Medicare, or private health insurance) in setting rates for outpatient services." Petition at 11. This statement is simply untrue. For example, the Medicare program has reimbursed hospitals on a reasonable cost basis for outpatient services in whole or in part since its inception in 1965. *See* 42 U.S.C. §§ 1395k(a)(2), 1395l(a)(2), 1395x(s)(2)(B). Thus, it is hardly unusual for governmental reimbursement programs to establish hospital outpatient rates based on provider costs.

(Cont'd)
outpatient services must bear a reasonable relationship to hospital costs. The Ohio Supreme Court, in *Ohio Hosp. Ass'n v. Ohio Dep't of Human Servs.*, 62 Ohio St. 3d 97, 579 N.E.2d 695 (Ohio 1991), *cert. denied*, 503 U.S. 940 (1992), upheld a trial court finding that rates which are less than the costs of efficient and economical hospitals are not consistent with efficiency, economy and quality of care.

The Department argues that the Ninth Circuit "overlooked the federal government's own longstanding interpretation of the 'efficiency, economy, and quality of care' provision. . . ." Petition at 12. The Department has failed to demonstrate where the federal government has stated that this provision does not encompass a minimum payment standard or does not require states to consider hospital costs when adopting hospital outpatient rates. Although the Department notes that federal regulations which have been adopted pursuant to Section 1396a(a)(30)(A) contain an upper limit on Medicaid payments, the Department fails to point to any regulation or other federal interpretation which indicates that this statute does not also encompass a minimum payment standard.

The Department emphasizes that Section 1396a(a)(30)(A) requires that payments be "consistent" with efficiency, economy, and quality of care, in contrast to the requirement that payments be "sufficient" to ensure access. Petition at 12-13. As the Ninth Circuit discussed in *Orthopaedic II/III*, " 'consistent' means in agreement with, compatible, or conforming to the same principles or course of action," and does not establish a standard that is "widely different" from "sufficient." *Orthopaedic Hosp.*, 103 F.3d at 1496 (Appendix A at 13).[8]

The Department in the Petition discusses at length the legislative history of Section 1396a(a)(30)(A). Petition at 14-17. This legislative history was thoroughly considered by the Ninth Circuit which concluded:

> Congress intended payments be flexible within a range; payments should be no higher

8. The amici curiae argue that quality of care may be assured by a regulatory scheme set up to monitor quality. Brief of Amici Curiae at 9-10. This argument was squarely rejected by the Ninth Circuit, which concluded that the statute requires the *payments* themselves to be consistent with quality of care. *See Orthopaedic Hosp.*, 103 F.3d at 1497 (Appendix A at 14-15).

> than what is required to provide efficient and economical care, but still high enough to provide for quality care and to ensure access to services.

Orthopaedic Hosp., 103 F.3d at 1497 (Appendix A at 16).[9]

Finally, the Department asserts that the Ninth Circuit's interpretation of Section 1396a(a)(30)(A) would render superfluous the Boren Amendment. Petition at 9. The Ninth Circuit expressly rejected this argument noting that substantial differences exist between the Boren Amendment and Section 1396a(a)(30)(A) as construed by the Ninth Circuit. *Orthopaedic Hosp.*, 103 F.3d at 1499 (Appendix A at 19).

II.

THE SECOND QUESTION PRESENTED — THE ABILITY OF HEALTH CARE PROVIDERS TO ENFORCE SECTION 1396a(a)(30)(A) UNDER 42 U.S.C § 1983

A. The Supreme Court Should Not Consider The Second Question Because It Was Not Presented To Or Considered By The Ninth Circuit

The Supreme Court has consistently stated that it will not review issues which were not raised below unless exceptional

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9. The amici curiae argue that the Ninth Circuit's decision is inconsistent with a 1981 amendment to the Medicaid Act. Brief of Amici Curiae at 11-13. That amendment, however, eliminated an *upper limit* on Medicaid payments, which prohibited payments from exceeding Medicare reasonable charge levels. *See* H.R. Rep. No. 158, part II, 97th Cong., 1st Sess. 312-13 (1981). The amendment left unchanged the requirement that payments be consistent with efficiency, economy, and quality of care, which is the language that imposes a lower limit on payment levels. The removal of an upper limit clearly does not support an argument that Congress intended no lower limit.

circumstances exist. *Granfinanciera, S.A. v. Nordberg*, 492 U.S. 33, 38-40, 109 S. Ct. 2782, 2788-89, 106 L. Ed. 2d 26 (1989); *Heckler v. Campbell*, 461 U.S. 458, 468 n.12, 103 S. Ct. 1952, 1958 n.12, 76 L. Ed. 2d 66 (1983); *Delta Air Lines, Inc. v. August*, 450 U.S. 346, 362, 101 S. Ct. 1146, 1155, 67 L. Ed. 2d 287 (1981); *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 147 n.2, 90 S. Ct. 1598, 1602-03 n.2, 26 L. Ed. 2d 142 (1970).

The Department challenged the Hospitals' ability to enforce Section 1396a(a)(30)(A) under 42 U.S.C. § 1983 before the district court in both *Orthopaedic I* and *Orthopaedic II/III*. The district court twice rejected the Department's position, holding that the Hospitals have a private right of action under 42 U.S.C. § 1983. *Orthopaedic Hosp.*, Nos. 94-4764, 94-4825 (C.D. Cal. Mar. 24, 1995) at 9 (Order Denying Plaintiffs' Motion for Summary Judgment and Granting Summary Judgment for Defendant) (Appendix B at 9) (*Orthopaedic II/III* Court reaffirming holding from *Orthopaedic I* that Section 1396a(a)(30)(A) is enforceable pursuant to 42 U.S.C. § 1983).

However, the Department did not raise the private right of action issue before the Ninth Circuit.[10] Accordingly, this Court should decline to review the issue.[11]

The circumstances here are very similar to those in *Adickes*. In that case, the petitioner asked the Court in its petition for a Writ of Certiorari to consider an issue that the petitioner had raised at the district court but had not raised before the court of appeals. The Supreme Court declined to review the issue noting

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10. The Department's failure to raise this issue before the Ninth Circuit is acknowledged by the amici curiae in their Brief at page 18.

11. The Department's failure to raise the private right of action issue in a timely fashion before the Ninth Circuit is deemed a waiver of that issue by the Ninth Circuit. *Boardman*, 957 F.2d at 1535.

that "[w]here issues are neither raised before nor considered by the Court of Appeals, this Court will not ordinarily consider them." *Adickes*, 398 U.S. at 147 n.2, 90 S. Ct. at 1603 n.2 (citations omitted).

The Court has on rare occasions reviewed issues not considered below where exceptional circumstances are present. For example, in *Youakim v. Miller*, 425 U.S. 231, 234, 96 S. Ct. 1399, 1401, 47 L. Ed. 2d 701 (1976), the Supreme Court accepted an issue which was not presented to a three judge district court. The Court found that exceptional circumstances were present because the district court would clearly have rejected the claim, the relevant agency's interpretation was issued after the decision of the district court, and consideration of the issue would be consistent with the Court's practice of avoiding decisions on constitutional matters. *Id.* at 236, 96 S. Ct. at 1402. Still, the court did not decide the issue, but remanded the matter to the district court. *Id.*

There are no similar exceptional circumstances here which would warrant the Supreme Court to ignore its usual policy in order to review the private right of action issue. This issue, therefore, should not be reviewed by the Court.

B. The Private Right Of Action Issue Is Not Of Sufficient Importance To Warrant Supreme Court Review

As discussed above, the Hospitals are aware of only five Court of Appeals decisions concerning claims brought by health care providers seeking to enforce Section 1396a(a)(30)(A) during the twenty-nine years since that statute was enacted. This is not indicative of an important question requiring Supreme Court resolution.

Further, the Supreme Court has provided substantial

guidance concerning when a private right of action is available under 42 U.S.C. § 1983 to enforce provisions of federal law, including a decision concerning another payment provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(13)(A). *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990). There is no need at this time for the Supreme Court to clarify further the criteria under which a private right of action will lie under 42 U.S.C. § 1983.

C. There Is No Conflict Among The Circuits

The Hospitals are aware of three Court of Appeals decisions addressing the question of whether health care providers have a private right of action under 42 U.S.C. § 1983 to enforce Section 1396a(a)(30)(A). In each case, the court held that Section 1396a(a)(30)(A) is enforceable through a Section 1983 action. *See Visiting Nurse Ass'n*, 93 F.3d at 1005; *Methodist Hosps.*, 91 F.3d at 1029; *Arkansas Medical Soc'y*, 6 F.3d at 528. Thus, there is no conflict among the circuits regarding the enforceability of Section 1396a(a)(30)(A).

D. The District Court Correctly Held That The Hospitals Have A Private Right Of Action To Enforce Section 1396a(a)(30)(A) Under 42 U.S.C. § 1983

The key case for analyzing the private right of action issue is *Wilder v. Virginia Hosp. Ass'n*. In *Wilder*, the Supreme Court held that health care providers may enforce the Boren Amendment under 42 U.S.C. § 1983. *Wilder*, 496 U.S. at 424, 110 S. Ct. at 2525. The Court adopted a three part test, including (1) whether the plaintiff is an intended beneficiary of the statute, (2) whether the statute reflects merely a congressional preference for a certain kind of conduct rather than a binding obligation imposed on a governmental unit, and (3) whether the statute is

so vague and amorphous that it is beyond the competence of the judiciary to enforce. *Id.* at 509, 110 S. Ct. at 2517.[12]

The Department contends that Section 1396a(a)(30)(A) was not intended to benefit health care providers. This contention appears to be based primarily on the Department's interpretation of that Section as not providing a minimum payment standard. As the Ninth Circuit held, however, Section 1396a(a)(30)(A) does establish a minimum payment standard, requiring that payments bear a reasonable relationship to costs. *Orthopaedic Hosp.*, 103 F.3d at 1496 (Appendix A at 13). A statute requiring that payments to providers bear a reasonable relationship to costs is clearly intended to benefit providers. *See Wilder*, 496 U.S. at 510, 110 S. Ct. at 2517. Furthermore, the argument that Section 1396a(a)(30)(A) was not intended to benefit health care providers was flatly rejected by the First and Eighth Circuits. *See Visiting Nurse Ass'n*, 93 F.3d at 1003-04; *Arkansas Medical Soc'y*, 6 F.3d at 526.

There can be no doubt that the second prong of the *Wilder* test is satisfied here. In *Wilder*, the Court emphasized that the Boren Amendment is "cast in mandatory rather than precatory terms: The state plan '*must*' 'provide for payment . . . of hospital[s]' according to rates the State finds are reasonable and adequate." *Wilder*, 496 U.S. at 512, 110 S. Ct. at 2519. Similarly, a state's Medicaid plan *must* comply with Section 1396a(a)(30)(A). *See Visiting Nurse Ass'n*, 93 F.3d at 1004-05.

Finally, Section 1396a(a)(30)(A) is not so vague and amorphous as to be judicially unenforceable. This is perhaps best reflected by the Ninth Circuit's decision here. The Ninth

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12. The Department relies heavily on *Suter v. Artist M.*, 503 U.S. 347, 112 S. Ct. 1360, 118 L. Ed. 2d 1 (1992). *Suter* has largely been overturned by Congress in enacting 42 U.S.C. § 1320a-2. Thus, *Suter* is of little precedential value, and the Department's reliance on it is misplaced.

Circuit had no difficulty in construing the statute and developing a test which can be judicially enforced, *i.e.*, that rates bear a reasonable relationship to hospital costs. Further, the statute contains objective benchmarks, including the benchmark of efficiency, economy, and quality of care, to which a court compares a state's payment rates. *See Wilder*, 496 U.S at 519-20, 110 S. Ct. at 2522-23; *Arkansas Medical Soc'y*, 6 F.3d at 527.

III.

RESPONSE TO AMICI CURIAE

For the most part, the amici curiae merely restate arguments made in the Petition and addressed above. However, the amici curiae present additional argument concerning the standard of review applied by the Ninth Circuit, arguing that the Ninth Circuit should have deferred to both federal and state agency interpretations of Section 1396a(a)(30)(A). Brief of Amici Curiae at 14-18 (citing *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984)).

As discussed above, there is no applicable relevant federal agency interpretation of Section 1396a(a)(30)(A) to which *Chevron* deference might apply. Further, "[a] state agency's interpretation of federal statutes is not entitled to the deference afforded a federal agency's interpretation of its own statutes under *Chevron* . . . ." *Orthopaedic Hosp.*, 103 F.3d at 1495 (Appendix A at 12).

The amici note that the Ninth Circuit relied in part on *Turner v. Perales*, 869 F.2d 140, 141 (2d Cir. 1989), which declined to defer to a state agency interpretation of federal law. Brief of Amici Curiae at 15-16. The amici then argue that *Turner* has

been distinguished in *Perry v. Dowling*, 95 F.3d 231 (2d Cir. 1996), which the amici characterize as affording deference to a state agency interpretation of federal Medicaid law.[13] Brief of Amici Curiae at 15-16. However, the Second Circuit decided that deference was appropriate in *Perry v. Dowling* because the Health Care Financing Administration ("HCFA"), a federal agency, had approved the state's Medicaid plan and had submitted an affidavit agreeing with the state's interpretation. *Perry*, 95 F.3d at 236-37. Thus, the Second Circuit found that there was sufficient federal involvement to warrant *Chevron* deference.[14]

Here, although HCFA has approved California's Medicaid state plan, that approval did not encompass the Department's interpretation of Section 1396a(a)(30)(A). Further, there is no evidence that HCFA agrees with the Department's interpretation. Thus, there has been insufficient federal involvement to warrant *Chevron* deference.

As the Ninth Circuit noted in *Orthopaedic II/III*, one of the underpinnings of *Chevron* is the "need for coherent and uniform

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13. The Ninth Circuit also relied on *AMISUB (PSL), Inc. v. Colorado Dep't of Social Servs.*, 879 F.2d 789, 796 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990), in which the Tenth Circuit declined to defer to a state agency's interpretation of the Medicaid Act. The amici attempt to dismiss *AMISUB* by stating that it arose under the Boren Amendment and has been characterized as an "extreme case." Brief of Amici Curiae at 16 n.12. However, the fact that *AMISUB* dealt with the Boren Amendment had nothing to do with that court's holding that deference should not be given to state interpretations of federal Medicaid law. Similarly, the characterization of *AMISUB* as an extreme case is based on the specific facts in that case, where, like the situation here, the Medicaid payments equalled 50 percent of hospital costs, and had nothing to do with the court's holding concerning deference.

14. In view of the federal interpretation of the statute at issue in *Perry v. Dowling*, it appears that the Second Circuit in fact deferred to a federal interpretation rather than a state agency interpretation.

construction of federal law nationwide." *Orthopaedic Hosp.*, 103 F.3d at 1495 (Appendix A at 12). Affording deference to each state agency's interpretation of federal law would be directly in conflict with this policy.

Finally, the amici criticize the Ninth Circuit's requirement that the Department rely on cost studies. Brief of Amici Curiae at 17. The Ninth Circuit's holding, however, is entirely consistent with this Court's decisions and the applicable standard of review. The Ninth Circuit applied an arbitrary and capricious standard of review. *Orthopaedic Hosp.*, 103 F.3d at 1500 (Appendix A at 22). This standard requires the court to determine whether the agency considered the relevant factors and made a reasonable connection between the factors and the agency's decision. *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 91 S. Ct. 814, 28 L. Ed. 2d 136 (1971). The Ninth Circuit determined that hospital costs are a relevant factor which the Department must consider in establishing hospital outpatient rates.[15] The Ninth Circuit quite reasonably concluded that in

15. The amici criticize the Ninth Circuit for having disregarded cost data contained in the administrative record because the Department did not base its decision on this data. Brief of Amici Curiae at 15 n.10. The Ninth Circuit properly disregarded the cost study. Under the arbitrary and capricious standard of review, a court must determine whether an agency considered the relevant factors when taking action, and the administrative record in this case reflected that the Department did not consider hospital costs in readopting the rates. Additionally, the cost study to which the amici refer is based on a comparison of total hospital costs to total hospital payments, including both inpatient and outpatient costs and payments, and did not focus on payments for hospital outpatient services. *Orthopaedic Hosp.*, 103 F.3d at 1495, 1500 (Appendix A at 10, 21). In contrast, a study submitted by the Hospitals' expert, which was included in the administrative record, was based solely on outpatient costs and services and demonstrated that the Department reimbursed only 41 percent of costs. Nonetheless, the Department's study showed that only 34 percent of hospitals were reimbursed at least 100 percent of their costs under Medi-Cal taking into account both inpatient and outpatient services. 3 A.R. at 21-22.

order for the Department to properly consider hospital costs, it must rely on a study of such costs. This is not the imposition of a new procedural requirement, but is simply a reasonable application of the arbitrary and capricious standard of review.[16]

CONCLUSION

The Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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16. The amici cite several Boren Amendment cases for the proposition that a deferential standard of review should be applied. Brief of Amici Curiae at 16-17 n.12. These cases all stand for the proposition that the appropriate standard of review is the arbitrary and capricious standard. This is precisely the standard that was used by the Ninth Circuit here. The amici appear to have confused the standard of review with the concept of deference to be afforded to an agency's interpretation of the statute. First, the statute must be interpreted to identify the relevant factors that must be considered by the agency, then the court must determine under the arbitrary and capricious standard of review whether the agency considered those factors. This is precisely what the Ninth Circuit has done.

APPENDIX A — MEMORANDUM AND ORDER OF THE UNITED STATES DISTRICT COURT, DISTRICT OF MINNESOTA, THIRD DIVISION FILED FEBRUARY 14, 1996

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
THIRD DIVISION

Civil File No. 3-94-1570

Minnesota Home HealthCare Association, Inc.; CommuniCare Home Care; First Respiratory, Services, Inc.; Kanabec County Public Health; Lake Region Hospital Home Health Care; McLeod County Public Health Nursing; Meeker County Public Health; Metropolitan Visiting Nurse Association; Pine to Prairie Home Health Care; PrairieLand Home Care, Inc.; R.E.M. Health, Inc.; Saint Cloud Hospital Home Care Services; St. Joseph's Hospital; St. Mary's Medical Center Home Care; Samaritan Bethany Home Health Services; Shamrock In-Home Nursing Care, Inc.; Sibley County Public Health Department,

Plaintiffs,

v.

Maria Gomez, Commissioner, State of Minnesota, Department of Human Services,

Defendant.

MEMORANDUM AND ORDER

This matter is before the Court on the parties' Cross-Motions for Summary Judgment. For the following reasons, Defendant's motion is granted and Plaintiffs' motion is denied.

Appendix A

I. BACKGROUND

Plaintiffs are 16 separate home health care providers in the State of Minnesota and the state association of 248 providers. Plaintiffs challenge the rate-setting methodology employed by the State of Minnesota for home health care providers under the state's Medical Assistance Program. Plaintiffs claim that Defendant is administering the program in violation of federal and state law.

Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., provides matching federal funds for state health programs that provide medical services for the indigent and others who may be denied access to medical care. To participate in this federal program, known as Medicaid, states must comply with federal regulations which govern the way in which the program is administered.

The federal Medicaid statute requires that states provide a variety of services as part of their medical assistance program, including home health services. 42 U.S.C. § 1396a(a)(10)(D); 42 C.F.R. § 441.15. Home health care includes nursing services, home health aides, medical supplies and equipment for home use, physical therapy, occupational therapy, and speech pathology. 42 C.F.R. § 440.70(b)(1)-(4). In addition, home health care agencies participating in the state program must be certified under the Medicaid program, *see* 42 C.F.R. § 440.70(b), and must meet the federal guidelines for participation. 42 U.S.C. §§ 1395x(o), 1395bbb; 42 C.F.R. § 484. These guidelines govern provider qualifications, reporting requirements, supervision, and other quality issues.

Appendix A

A. *Rate-Setting Requirements*

While the federal Medicaid statute does not mandate any specific rate-setting system, it does require that states

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(30)(A).

Minnesota has chosen to participate in the cooperative state-federal Medicaid program. The Minnesota Medical Assistance program provides home health care as one of its covered services. The rates for reimbursement for home health care providers are governed by rule and statute. By statute, the legislature directed the Medical Assistance program to

> place limits on the types of services covered by medical assistance, the frequency with which the same or similar services may be covered by medical assistance for an

> individual recipient, and the amount paid for each covered service.

Minn. Stat. § 256B.04, subd. 12. The Minnesota Rules provide that

> [f]or home health agency services, the rate shall be the lower of the provider's submitted charge or the Medicare cost per visit limits based on Medicare cost reports submitted by freestanding home health agencies in the Minneapolis and St. Paul area in the calendar year specific in legislation governing maximum payment rates for services.

Minn. Rules 9505.0445J (1993). At the time the rule was adopted, the legislature had selected 1982 as the base year for calculating maximum reimbursement rates. 1985 Minn. Laws, 1st Spec. Sess., ch. 9, art. 1, § 2, subd. 5(b). Under this scheme, providers would receive the lower of either the maximum payment allowed under Medicaid in 1982 or the provider's submitted charges.

In 1992, the legislature considered rates for medical services under the Medical Assistance program. The legislature voted to change the base year calculation for Medicaid repayment rates from 1982 to 1989 for noninstitutional medical practitioners. However, the legislature specifically excluded home health care providers from this increase. Minn. Stat. § 256B.76(a)(3) (1994). The legislature provided that home health care reimbursement rates would remain at the rate in place on September 30, 1992. *Id.* The 1992 rate used 1982 as the base year. In 1993, the legislature voted to increase reimbursement

rates for home health providers by 3%. 1993 Minn. Laws, 1st Spec. Sess., ch. 1, art. 1, § 2, subd. 4. There have been no other alterations to the reimbursement rates for home health providers.

Plaintiffs claim that Defendant's method for setting rates violates the federal Medicaid statute. Plaintiffs contend that Defendant does not maintain a methodology for rate analysis that adequately considers efficiency, economy, quality of care, and access to services. Plaintiffs do not challenge current rates paid by Defendant or specific rate changes. Rather, Plaintiffs ask this Court to order Defendant to develop a methodology that conforms to the dictates of federal law. In addition, Plaintiffs claim that in 1985, the Minnesota legislature repealed the statute designating a base year for determining reimbursement rates. Plaintiffs ask this Court to order reimbursement at providers' submitted rates until Defendant adopts a program that complies with federal and state law.

II. STANDARD OF REVIEW

Summary judgment is appropriate if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986); *Unigroup, Inc. v. O'Rourke Storage & Transfer Co.*, 980 F.2d 1217, 1219-20 (8th Cir. 1992). The court determines materiality from the substantive law governing the claim. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). Disputes over facts that might affect the outcome of the lawsuit according to applicable substantive law are material. *Id.* A material fact dispute is "genuine" if the evidence is sufficient to allow a reasonable jury to return a verdict for the non-moving party. *Id.* at 248-49.

Appendix A

III. DISCUSSION

A. *Claims Under 42 U.S.C. § 1396a(a)(30)(A)*

Both parties agree that the issues presented in this case can be fully addressed at the summary judgment level. Plaintiffs argue that the federal Medicaid statute requires a formalized methodology for determining reimbursement rates for home health providers. They argue that while the State of Minnesota may have been in compliance when the rate scheme for medical assistance was originally adopted, there is virtually no real oversight or evaluation of the program to determine whether the rate scheme continues to meet the criteria required by federal law. Plaintiffs do not provide evidence that citizens of Minnesota have been denied home health care services as a result of deficient rates. However, Plaintiffs do offer evidence that the state Medical Assistance Program may face accessibility problems in the future.

Defendant contends that the federal statute does not require a formalized evaluation process. They argue that the state is required to consider efficiency, economy, and accessibility when setting or changing rates, but that these rates need only be altered when accessibility is affected.

Several federal cases have addressed the responsibilities of states to set rates in conformance with the federal Medicaid statute. However, plaintiffs in all of these cases challenged rate or system changes. None of the cases have addressed a state's responsibilities in developing a rate-making methodology outside of a challenge to specific legislative or administrative action.

Appendix A

Plaintiffs cite numerous cases which arise under the Boren Amendment to the Medicaid Act. 42 U.S.C. § 1396a(a)(13)(A). The Boren Amendment applies to nursing and hospital services and requires a state to pay reimbursement rates that it "finds, and makes assurances to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality." *Id.* The factors outlined in the Boren Amendment are similar to those listed in 42 U.S.C. § 1396a(a)(30). In cases challenging state actions creating or changing state rate-making schemes under the Boren Amendment, courts have uniformly invalidated the change where states failed to make formal findings regarding efficiency, economy, and quality of care. *See Pinnacle Nursing Home v. Axelrod,* 928 F.2d 1306 (2d Cir. 1991) (finding that the state reimbursement scheme was adopted without the necessary findings and assurances); *AMISUB (PSL) v. State of Colorado DSS,* 879 F.2d 789 (10th Cir. 1989), *cert. denied,* 110 S. Ct. 3212 (1990) (finding that state failed to make proper findings under the Boren Amendment and that resulting rates violated efficiency and economy requirement); *Missouri Health Care Ass'n v. Stangler,* 765 F. Supp. 1413, 1415-16 (W.D. Mo. 1991) (invalidating rate change for long-term care facilities where state failed to make clearly mandated "findings"); *Multicare Med. Ctr. v. State of Washington,* 768 F. Supp. 1349 (W.D. Wash. 1991) (invalidating reimbursement scheme where state failed to make required findings).

However, it is clear that 42 U.S.C. § 1396a(a)(30)(A) does not require the same formalized findings as the Boren

Amendment. The Boren Amendment does not merely require that rates be consistent with the designated factors; it requires actual findings and assurances to the Secretary. The Boren Amendment mandates different requirements for hospital and nursing services than those services still governed by 42 U.S.C. § 1396a(a)(30)(A), such as home health care. No actual findings are required under 42 U.S.C. § 1396a(a)(30)(A). *California Association of Bioanalysts v. Rank*, 577 F. Supp. 1342, 1359 (C.D. Cal. 1983) ("Neither § 1396a(a)(30) nor its implementing regulations require a state or its Medicaid agency to explicitly consider and make findings on efficiency, economy, and quality of care before setting or implementing reimbursement rates"). It seems unlikely that Congress would have amended a statute to require explicit findings for nursing and hospital reimbursement rates if such findings were already required under the statute. This Court will not read into 42 U.S.C. § 1396a(a)(30)(A) a requirement that would render much of the substance of the Boren Amendment superfluous.

Courts have also invalidated rate changes under 42 U.S.C. § 1396a(a)(30)(A). Where states have given no consideration to issues of efficiency, economy, quality of care, and access to services, courts have found that rate setting or changes to existing rates failed to comply with federal law. Additional factors, such as budgetary concerns, are not legitimate reasons for rate alterations. *Arkansas Medical Soc., Inc. v. Reynolds*, 6 F.3d 519, 529-30 (8th Cir. 1993) (upholding invalidation of across the board 20% rate reduction and cost-sharing measures where adopted in order to balance Medicaid budget); *Orthopaedic Hosp. v. Kizer*, No. 90-4209, 1992 WL 345652 (C.D. Cal.) (invalidating rate changes where state failed to consider the appropriate factors); *Ohio Hosp. Ass'n v. Ohio Dep't of Human Servs.*, 579 N.E.2d 695, 698-99 (Ohio 1991),

cert. denied, 112 S. Ct. 1483 (1982) (finding that a reduction in reimbursement rates for outpatient services based on budgetary constraints did not fully consider factors).

All of these cases deal with state action changing reimbursement rate schemes. Parties have not cited any cases which address the procedural requirements of the Medicaid statute outside the context of an affirmative rate change by the state. However, the reasoning of the court in *California Association of Bioanalysts v. Rank* is instructive on this issue. 577 F. Supp. 1342 (C.D. Cal. 1983). In *Bioanalysts,* the court considered whether a twenty-five percent reduction in rates was valid under § 1396a(a)(30). *Id.* The court found that the state was not explicitly required to consider and make findings with regard to the statutory factors. Like the Plaintiffs in this case, the *Bioanalysts* plaintiffs appeared to have alleged that by failing to consider the factors, rates would be too low to provide sufficient access to services.

> Plaintiffs did not establish that any medicaid recipient in California in fact has been denied the requisite "equal access" to laboratory services as a result of the 25% reimbursement rate reduction for laboratories. Consequently, plaintiff's "efficiency, economy, and quality of care" challenge must fail.

Id. at 1360. The court found that subject to the equal access provisions of the federal regulations, "if a state's rate structure in fact fails to enlist enough providers to conform with [the equal access regulations], recipients or providers may bring an action to enjoin utilization of the rate structure until it is upwardly revised." *Id.* at 1359; *see also Orthopaedic Hosp. v. Belshe,*

Nos. CV 94-4764, CV 94-4825, slip. op. at 12 (C.D. Cal. Mar. 20, 1995) (finding unpersuasive the argument that rates must ensure quality of care where no evidence of lack of access to services by quality providers).

This Court finds that the Medicaid statute does not require the kind of formalized methodology advocated by the Plaintiffs. While a formal, rigorous analysis of such important programs may be desirable, such a methodology is not mandated by the statute. By the general language of the statute and regulations, states are allowed flexibility in developing their rate-setting schemes. Even under the Boren Amendment, courts have recognized that states have flexibility in considering statutory factors and making findings. *See AMISUB,* 879 F.2d at 797.

Defendant has an informal system of monitoring complaints, access, and provider quality. Defendant periodically assesses plan access, quality, and subscribership. Plaintiffs do not contend that the rates paid are excessive, nor do they claim that the rate-setting structure was invalid when adopted. Plaintiffs offer evidence to show that without a formal analysis of reimbursement rates, access will be denied in the future. Hopefully, the state legislature or administrative agency will take heed of Plaintiffs' warnings. If they do not, and access is denied to qualified recipients, providers and recipients may have a cause of action. However, the fact that the state has not maintained a formal program, where no access to services has been denied, is not a violation of the federal medicaid statute.

B. *11th Amendment*

In their Third Claim for Relief, Plaintiffs contend that Defendant has failed to comply with Minn. Rules pt.

9505.0445J by failing to designate a base year for reimbursement rate calculations. Defendant contends that the 11th Amendment of the United States Constitution prevents this Court from considering this issue. Plaintiffs failed to respond to this argument in any of their memoranda.

This Court agrees with Defendant that the 11th Amendment prevents this Court from hearing Plaintiffs' state law claims. As the Supreme Court held in *Pennhurst State Sch. & Hosp. v. Halderman,* 104 S. Ct. 900, 917 (1984), "a federal suit against state officials on the basis of state law contravenes the Eleventh Amendment when — as here — the relief sought and ordered has an impact directly on the State itself." The Court found this principle applicable even where the state claims raised are pendant to other federal claims. *Id.* at 919. In light of *Pennhurst,* this Court lacks the authority to decide Plaintiffs' state law claims.

C. *Base Year Calculations and Limits Set by the Legislature*

Plaintiffs' complaint alleges that the reimbursement rates for home health providers violate federal Medicaid regulations because the Minnesota legislature failed to designate a year by which to calculate Medicaid reimbursement rate caps. Prior to 1985, the reimbursement rate base year had been designated by the legislature as 1979. Minn. Stat. § 256.967 (1984). In 1985, the legislature repealed the statute which designated 1979 as the base year, and indicated that 1982 would be the appropriate year. *See* 1985 Minn. Laws, 1st Spec. Sess., ch. 9, art. 2, § 104; 1985 Minn. Laws, 1st Spec. Sess., ch. 9, art. 1, § 2, subd. 5(b). The legislature continued to affirm this base year through appropriations bills in 1987 and 1989. *See* 1987 Minn. Laws, ch. 403, art. I, § 2, subd. 6(b); 1989 Minn. Laws, ch. 282, art. I, § 2, subd. 7(a). Defendant has continued to use

1982 as the base year for calculating the Medicare reimbursement rate cap. In 1993, the state legislature indicated that rates for home health care would remain at the rates in effect on September 30, 1992. 1993 Minn. Laws, 1st Spec. Sess., ch. 1, art. 5, § 131(a)(3). Aside from a three percent increase in rates enacted in 1993, the 1982 rates have been the only ones used by Defendant.

In their Memorandum in Support of Summary Judgment, Plaintiffs argue that when Minn. Stat. § 256.967 (1984) was repealed, there was no longer any legislatively authorized base year for the reimbursement rate cap. Apparently, Plaintiffs overlooked appropriations bills which set the reimbursement rate at the 1982 level. In 1985, the same year the legislature repealed the statute that designated the base year for rate calculations, the legislature adopted 1982 as the base year through its appropriations bill. 1985 Minn. Laws, 1st Spec. Sess., ch. 9, art. 1, § 2, subd. 5(b). This Court rejects the argument outlined in Plaintiffs' Complaint alleging that the legislature failed to designate an appropriate base year when it repealed Minn. Stat. § 256.967 (1984) in 1985. In their Memorandum in Opposition to Defendant's Motion for Summary Judgment, Plaintiffs seem to concede that Defendant is in compliance with state rate-setting requirements regarding base year designations. This Court finds that the legislature adopted 1982 as the base year for reimbursement rate calculations through its 1985 appropriations bill.

However, Plaintiffs suggest in their response memorandum that Defendant has violated 42 C.F.R. § 447.205 by improperly amending the state's reimbursement methodology. This Court will not address Plaintiffs' argument. No formal amendment to the complaint has ever been filed with this Court. This issue

has not been fully briefed and it would be inappropriate to visit this issue without a formal complaint and fair opportunity for Defendant to respond.

III. CONCLUSION

Because Defendant's current rate methodology does not violate federal law, this Court grants Defendant's Motion for Summary Judgment with respect to Plaintiffs' First Claim for Relief. The 11th Amendment prevents this Court from hearing Defendant's state law claims. This Court dismisses Plaintiffs' Third Claim for Relief without prejudice. Since the Minnesota legislature's repeal of Minn. Stat. § 256.967 did not ultimately repeal the base year designation for reimbursement calculations, this Court grants Summary Judgment for Defendant with respect to Plaintiffs' Second Claim for Relief.

Accordingly, **IT IS HEREBY ORDERED THAT:**

Defendant's Motion for Summary Judgment is GRANTED. Plaintiffs' First and Second Claims for Relief are DISMISSED WITH PREJUDICE. Plaintiff's Third Claim for Relief is DISMISSED WITHOUT PREJUDICE.

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: February 14, 1996

s/ Paul A. Magnuson
PAUL A. MAGNUSON
United States District Court Judge